Department of Veterans Affairs **VHA DIRECTIVE 2000-037**
Veterans Health Administration
Washington, DC 20420 **October 6, 2000**

APPLICATION OF THIRD-PARTY REIMBURSEMENT (BASED ON REASONABLE CHARGES) TO VETERAN COPAYMENTS

1. PURPOSE: This Veterans Health Administration (VHA) Directive implements new simplified procedures for the application of reimbursements from all third-party health plans (both Medigap and non-Medigap) to veterans' copayment debts.

2. BACKGROUND

a. The implementation of the Department of Veterans Affairs' (VA) reasonable charges for billing health insurance carriers has presented time-consuming and costly administrative difficulties in applying insurance reimbursements, particularly to the VA copayment obligations of non-Medicare-eligible veterans.

b. With the implementation of Reasonable Charges, multiple bills are generated for hospital charges and professional charges for each episode of inpatient care and each outpatient encounter. Some insured veterans are covered under more than one policy, necessitating multiple bills to two or more carriers for the same episode of care. In such circumstances, facilities must coordinate available benefits between separate insurance carriers and determine which carrier has primary or secondary liability for VA's charges for that episode of care. The multiple bills generated under reasonable charges result in a continuous stream of multiple reimbursements from health plans necessitating frequent adjustments to veterans' VA copayment obligations.

c. In the case of insured non-Medicare-eligible veterans, previous guidance required not only knowledge of the deductibles and copayments in the veteran's insurance coverage (information not always readily available or forthcoming from the insurer), but also calculations of the carrier's percentage of payment after deducting the copayments imposed under the coverage. In view of the multiple bills and reimbursements generated under reasonable charges, application of reimbursements to non-Medicare-eligible veterans' VA copayment obligations has become far more complicated, time consuming, and costly. In order to make VA's collections from both third-party health plans and veterans more cost-effective, this directive provides procedural changes to the manner in which third-party reimbursements are applied to veterans' VA copayment debts.

3. POLICY: It is VHA policy that veterans who incur VA medical care copayment obligations and who have health care insurance should be allowed the benefit of that insurance, to the extent of and consistent with the available plan coverage, toward the satisfaction of their VA obligations.

4. ACTION: The medical center Director must ensure that the following procedures are implemented.

a. Veterans who incur VA copayment obligations and who have health insurance should be allowed the benefit of that insurance, to the extent of and consistent with available coverage, toward satisfaction of their VA obligation. However, if the services billed to the insurance carrier are not covered services under that individual insurance plan (e.g., health care provided

by a non-MD provider, prescriptions), then no portion of the reimbursement can be applied to the copayment that corresponds to that service. The entire copayment will remain the veteran's responsibility and the veteran will be billed for any unpaid copayment balances.

b. Without regard to the type of health plan coverage that a veteran may have (Medigap or non-Medigap), effective with the date of this directive, all reimbursements from any health plan for VA care or services will be applied dollar-for-dollar to the veteran's copayment obligation. This will apply regardless of whether the veteran is Medicare-eligible and covered under a plan that supplements or coordinates available benefits with Medicare, or is not Medicare-eligible and covered under some other form of health coverage. As a result of this change, neither contacting the carrier to determine policy deductibles and copayments nor calculating the percentage of the reimbursement to be applied to non-Medicare-eligible veterans' VA copayment debts will be required.

c. If application of the third-party receivable to the veteran's VA copayment debt does not extinguish the debt for that episode of care, the open copayment balance remains the veteran's responsibility and the veteran will be billed.

d. Insurance carrier reimbursements will be applied to the veteran's VA copayment(s) corresponding to the episode(s) of care (inpatient or outpatient) or prescription(s) for which the insurance carrier was billed. Reimbursements should not be automatically applied to the oldest copayment on hold. In other words, facilities will need to match the dates of service that were billed to the insurance carrier with the corresponding VA copayment for that same episode of care before any application of the insurance reimbursement to the veteran's VA copayment can be made.

e. To avoid unnecessary billing, facilities will, to the extent supported by the Integrated Billing software, place copayment charges on hold for a period not to exceed 90 days.

f. When appropriate payment is received from the insurance carrier, this amount will be posted to the third-party receivable. If the payment does not cover the total cost of the receivable, the remaining third-party receivable balance will be contract-adjusted to zero. The first-party copayment charge will be released from Integrated Billing to Accounts Receivable. Facilities will make a decrease adjustment to the copayment charge in an amount up to the full amount of the payment from the insurance carrier for the corresponding episode of care billed and will record the appropriate comment. Refer to the attachment for examples.

g. **Copayment Billing.** Effective with the date of this directive, insured veterans responsible for VA copayment(s) for their VA health care will not be billed those copayment(s) until the veteran's health plan either:

(1) Remits payment in an amount that does not fully satisfy the veteran's VA copayment debt for that episode of care, in which case the veteran remains responsible for the open balance;

(2) Denies payment, in which case the veteran remains responsible for the entire VA copayment debt for that episode of care; or

(3) Fails to respond within the appropriate follow-up period after submission of VA's initial claim either by remitting payment or requesting additional information (such as VA medical records), in which case the veteran remains responsible for the entire VA copayment for that episode of care. Any applicable reimbursement subsequently received from such a health plan, however, must always be applied to the veteran's copayment debt, with refunds given if otherwise in order.

h. **Tort feasor and Workers' Compensation Exception.** When VA asserts its bill for medical care in a tort feasor or workers' compensation case, and against the veteran's health plan for that same care, complex questions often arise about application of third-party proceeds. The manner in which proceeds will be applied in such cases generally will depend on the nature, scope, and intent of the resolution of the tort feasor or workers' compensation claim.

(1) For instance, a judgment or a settlement of a tort feasor or workers' compensation case usually requires a compromise of all of the mutual interests of the parties. Such a settlement, therefore, may require refund of any VA copayments paid by the veteran, or write-off of any pending unpaid VA copayments. Often VA copayments that have been remitted can be considered in the overall settlement, obviating the need for refund. Pending copayments usually should be written off.

(2) Furthermore, when reimbursement also has been received from a third-party health plan in such cases, coordination of benefit requirements in many plans, as well as State law, may create an obligation to refund. In all such cases, the Regional Counsel, who has jurisdiction of tort feasor and workers' compensation claims, should be consulted for determination of these issues.

NOTE: *Regional Counsels are to be consulted for a determination of the issues in those instances where VA's care, or the injury that led to such care, is likely to result, or has resulted, in a claim for damages against the United States under the Federal Tort Claims Act.*

5. REFERENCE: None.

6. FOLLOW-UP RESPONSIBILITY: The VHA Office of Finance (174) is responsible for the contents of this directive.

7. RESCISSIONS: VHA Directive 99-014 is rescinded. This VHA Directive expires October 31, 2005.

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Under Secretary for Health

Attachment

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ATTACHMENT A

APPLICATION OF HEALTH INSURANCE REIMBURSEMENTS TO VETERANS' COPAYMENTS

The following instructions should be followed when a third-party reimbursement has been received and the veteran has an outstanding Department of Veterans Affairs (VA) copayment obligation for the episode of care related to that reimbursement. Insurance reimbursements will be applied dollar-for-dollar to the veteran's VA copayment obligation. Effective with the date of this directive, calculations to determine the percentage amount of reimbursement received from the non-Medigap insurance carrier no longer will be required.

1. When appropriate payment is received from the insurance carrier, this amount will be posted to the third-party receivable. If the payment does not cover the total amount of the receivable, the remaining third-party receivable balance will be contract-adjusted to zero. The first-party copayment charge will be released from Integrated Billing to Accounts Receivable. Facilities will make a decrease adjustment to the copayment charge in an amount up to the full amount of the payment from the insurance carrier for the corresponding episode of care, and will record the appropriate comment.

2. If the reimbursement from the insurance carrier does not cover all of the services for which the claim was submitted, the reimbursement will only be applied to the copayment for the covered services. If application of the third-party receivable to the veteran's copayment debt does not extinguish the debt for that episode of care, the open copayment balance remains the veteran's responsibility and the veteran will be billed.

a. As an example, if the billed services were for medical care provided by a physician assistant and the insurance carrier makes no reimbursement because it does not cover physician assistant-provided services, the veteran will be billed for the entire copayment amount. As an additional example, the insurance carrier was billed for an office visit and for prescriptions. The carrier submits reimbursement for the office visit and indicates that prescriptions are a non-covered service.

b. The copayment for the outpatient visit would be satisfied to the extent of the insurance reimbursement and any remaining unpaid balance for the outpatient copayment would be billed to the veteran. In this instance, since the prescriptions were a non-covered service, none of the insurance reimbursement would be applied toward the prescription copayment and the veteran would be billed for the entire prescription copayment amount.

3. To avoid unnecessary billing, facilities will, to the extent supported by the Integrated Billing software, place copayment charges on hold for a 90-day period pending response to VA's third-party claim.

4 . Examples

a. A Priority Group 7 veteran has an outpatient visit in the Urology Clinic and has ambulatory surgery. Claims are prepared for the institutional charges of $4,954.00 and for professional fees of $4,443.00. The veteran's copayment charges of $50.80 are placed on hold.

(1) For this outpatient treatment (OPT) visit, the carrier reimbursed 100 percent of the billed facility charges. Payment to the third-party receivable is recorded as $4,954.00 and the claim is closed. The veteran's copayment charges on hold total $50.80 and are released. A decrease adjustment is recorded for the copayments and an appropriate comment is recorded to reflect copayment paid in full by insurance reimbursement. In this instance, the insurance reimbursement satisfied the copayment debt in full and there is no copayment balance to bill the veteran.

(2) The insurance carrier subsequently provides 100 percent reimbursement for the professional fees for the OPT visit totaling $4,443.00. Payment to the third-party receivable is recorded as $4,443.00 and the claim is closed. Since the veteran's copayment was fully satisfied with the initial payment and has been closed, no further action is required.

b. A Priority group 7 veteran has an outpatient appointment and receives one prescription. A claim is prepared for the outpatient visit of $52.31 and $36.00 for the prescription which total $88.31. The veteran's outpatient copayment of $50.80 and the prescription copayment of $2.00 are placed on hold.

(1) For the outpatient visit, the insurance carrier allows $45 and reimburses 80 percent of the $45 which total $36.00. For the prescription, the insurance carrier reimburses $10. Payment to the third-party receivable is recorded as $46. The remaining balance of $42.31 is contract-adjusted to zero and the claim is closed.

(2) The veteran's copayment charges on hold total $52.80 and are released. For the outpatient copayment, since the reimbursement from the insurance carrier totaled $36.00, this does not fully satisfy the outpatient copayment. A decrease adjustment is recorded for the outpatient copayment and the remaining unpaid outpatient copayment charges of $14.80 are released to the veteran. For the prescription copayment, the insurance carrier reimbursement fully satisfied the prescription copayment and there are no charges to be released to the veteran for the prescription copayment. A decrease adjustment is recorded for the prescription copayment and an appropriate comment is recorded to reflect copayment paid in full by insurance reimbursement.

c. A Priority group 7 veteran has an outpatient appointment and receives one prescription. A claim is prepared for the outpatient visit of $52.31 and $36.00 for the prescription, which total $88.31. The veteran's outpatient copayment of $50.80 and the prescription copayment of $2.00 are placed on hold.

(1) For the outpatient visit, the insurance carrier allows $45 and reimburses 80 percent of the $45 which total $36.00. For the prescription, the insurance carrier indicates that prescriptions are not covered services and provides no reimbursement for the charge. Payment to the third-party

receivable is recorded as $36.00. The remaining balance of $52.31 is contract-adjusted to zero and the claim is closed.

(2) The veteran's copayment charges on hold total $52.80 and are released. A decrease adjustment of $36.00 is recorded for the outpatient copayment and the remaining unpaid outpatient copayment balance of $14.80 is released for billing to the veteran. An appropriate comment is recorded to reflect copayment paid by insurance reimbursement. Since the insurance carrier indicated that prescriptions were a non-covered service, none of the insurance reimbursement is applied to the prescription copayment. The prescription copayment of $2.00 is the veteran's responsibility and this charge is released. In this instance, the insurance reimbursement did not satisfy in full the total outpatient copayment debt or any of the prescription copayment debt so the remaining unpaid copayment balance is the responsibility of the veteran.

d. A Priority Group 7 veteran has an outpatient visit in the Internal Medicine Subspecialty/Rheumatology Clinic. The veteran is a retired Federal employee with Medicare Part A benefits and coverage under a Federal Employee Health Benefit Plan (FEHBP). The FEHBP has indicated that it will reimburse 70 percent of claims submitted because the patient is a retired Federal employee with Medicare Part A, so the FEHBP is primary for all outpatient charges.

(1) A claim is submitted for $261.59. The veteran's copayment charges of $50.80 are placed on hold. The FEHBP properly reimburses 70 percent of the billed charges, by submitting a payment of $183.11. Payment to the third-party receivable is recorded as $183.11 and the remaining balance of $78.48 is contract-adjusted to zero and the claim is closed.

(2) The veteran's copayment charges on hold total $50.80 and are released. A decrease adjustment is recorded for the copayment and an appropriate comment is recorded to reflect copayment paid in full by insurance reimbursement. In this instance, the insurance reimbursement satisfied the copayment debt in full and there is no copayment balance to bill the veteran.

e. A Priority Group 7 veteran is admitted as an inpatient to the Intermediate Care Unit for 4 days and is then transferred to the Surgical Care Unit for 16 days. The patient was discharged after completing a 20-day length of stay. A claim is prepared for the inpatient episode of care for facility charges of $42,696.00. Claims are also submitted for the professional fees of $10,945.90. The veteran's inpatient copayment of $776 plus the per diem copayments of $200 are placed on hold.

(1) The carrier reimburses the facility charges with a payment of $39, 601. Payment to the third-party receivable is recorded as $39,601 and the remaining balance of $3,095 is contract-adjusted to zero and the claim is closed. The veteran's copayment charges on hold total $976 and are released. A decrease adjustment is recorded for the copayments and an appropriate comment is recorded to reflect copayment paid in full by insurance reimbursement. In this instance, the insurance reimbursement satisfied the copayment debt in full and there is no copayment balance to bill the veteran.

(2) The insurance carrier subsequently provides reimbursement for the professional fees for the inpatient admission totaling $10,945.90. Payment to the third-party receivable is recorded as $10,945.90 and the claim is closed. Since the veteran's copayment was fully satisfied with the initial payment and has been closed, no further action is required.